Appointment: Date_____ **Time**_____ **Worker**_____ **Case #**_____

Medical Application For Long Term Care

DOH-61LT 10-00

Utah Department of Health

Answer the questions on this form to apply for Nursing Home or other medical institution or Medicaid Waiver programs. The questions refer to the person who needs the help. Questions 18, 19, an 20 do not apply to Waiver applicants.
If you need help completing this form, please let us know.

Your Name_____ Sex_____ Marital Status_____

Birth Date_____ Social Security Number_____ Phone Number_____

Address _____ City _____ Zip Code_____

Mailing Address_____ City_____ Zip Code_____

Nursing Home Name_____ Waiver Name_____

Who Lives In Your Home?

List the people who are living in your home while you are receiving nursing home or other long term care or care through a waiver program.

Name	Sex	Relationship	Birth Date	Social Security Number	Marital Status
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1. Are you a Utah resident? . . . . . **9** Yes **9** No
   If no, please explain: _____
2. Are you a U.S. citizen? . . . . . **9** Yes **9** No
3. When do you want the Medicaid help to begin? _____
4. If you are living in a nursing home/institution:
   Give the date you entered._____
   Where did you live before you entered the facility? _____
   If you lived in another facility, which one?_____ When_____
   Has your marital status changed since you entered? . . . . . **9** Yes **9** No
   Did you enter the facility from the hospital? If yes, which hospital?_____
   Date you entered the hospital _____ Date discharged_____
   Do you intend to return home? **9** Yes **9** No If yes, when: 6 months **9** 90 days **9** Other _____
5. Do you want a friend or relative to help with your case? **9** Yes **9** No
   If yes, please list name, address, and phone number._____
   _____
   Does this person have power of attorney, legal guardianship, etc for you? . . . . . **9** Yes **9** No

6. If you are a Veteran of the U.S. Armed Forces or have been claimed as a dependent of a Veteran:
   List name of Veteran _____ Relationship _____
   Did the Veteran serve in wartime? . . . . . **9** Yes **9** No
   Has the Veteran ever received V.A. benefits? . . . . . **9** Yes **9** No
   Does the Veteran have a service connected disability? . . . . . **9** Yes **9** No
   Is the Veteran deceased? . . . . . **9** Yes **9** No
   Was the death service connected? . . . . . **9** Yes **9** No
   Was the Veteran in the Armed Forces at the time of death ? . . . . . **9** Yes **9** No

7. Assets - List any assets owned by you and your spouse. Include anyone else's assets in which you or your spouse are a joint owner, signer, or trustee. Assets are things like bank accounts, cash, homes or real estate, IRA or 401K, stocks/bonds, notes, annuities, jewelry, livestock, water shares, oil/mineral rights, life insurance, funeral plans, burial spaces, etc. Include any personal household items that could be sold for $500 or more. List vehicles in the next section.

Type of Asset	Owner(s)	Account number	Value	Amount Owed

Vehicles - (Car Truck/Van Other Vehicle Motor Home Motor Cycle Snowmobile Boats/Motors etc.)

Type of Vehicle	Make	Model	Year	Licensed Yes/No Lic. # / State	Owner/ Joint Owners	Amount Owed	Current Value

8. Does anyone owe money to you or your spouse, such as a sales contract? . . . . . **9** Yes **9** No
   If yes, please explain_____
9. Have you sold or given away any assets you used to own in the last 36 months? . . . . . **9** Yes **9** No
   If yes, please explain_____

10. Do you have a trust? **9** Yes **9** No Have you transferred anything into or out of the trust in the last 60 months? **9** Yes **9** No If yes, please explain_____

11. Income - List all income received by you or your spouse. Include income from, Social Security, SSI, Civil Service, Railroad Retirement, Veterans Benefits, retirement income, pensions, disability income, earnings, self-employment, unemployment, child support, alimony, church assistance, rental income, cash gifts, interest income, income from investments, inheritance or settlement income, etc.

		Income Type	Amount of Income	How Often Paid
Self	Ø			
	Ù			
	Ú			
Spouse	Ø			
	Ù			
	Ú			

12. Do you expect any changes in your or your spouses income? . . . . . **9** Yes **9** No
If yes, explain: _____

13. Has anyone applied for any type of income that is not yet being received? . . . . . **9** Yes **9** No
If yes, explain_____

14. If you are not currently employed, when did you last work for pay? _____ Your spouse?_____

15. Does any person or organization give you money to pay expenses? . . . . . **9** Yes **9** No

Other Information

16. Do you live at home or have a spouse or other dependent at home? . . . . . **9** Yes **9** No

Please list the following:			
Utilities (electric, heat, telephone)	$_____	Rent or Mortgage	$_____
Property Taxes if not included	$_____	Second Mortgage	$_____
Condo Fee	$_____	Trailer Space Rental	$_____
		Homeowners Insurance	$_____

17. Does anyone help you or your spouse or dependent pay these expenses? . . . . . **9** Yes **9** No
If yes, give name and relationship _____

18. Is Medicare paying for any of your days in the nursing home? . . . . . **9** Yes **9** No
If yes, which days?_____

19. Is Veteran's Administration paying for any of your days in the nursing home? . . . . . **9** Yes **9** No
If yes, which days?_____

20. Do you have any other help in paying for the nursing home? . . . . . **9** Yes **9** No
If yes, please explain_____

21. Do you want help with any unpaid medical bills? . . . . . **9** Yes **9** No

22. If you have medical insurance, how much do you pay?_____ How often do you pay? _____
When is the next payment due?_____ Who pays the premium?_____
Does the insurance include your spouse? . . . . . **9** Yes **9** No

THIRD PARTY AND INSURANCE INFORMATION

Name: Birthdate: Case#:

Î Do you have health insurance? ‘ Yes ‘ No
If you answered yes, complete Section 1.

Ï Have you or any household member been injured in an accident or assault? ‘ Yes ‘ No
If you answered yes, complete Section 2.

Ð Does someone in your home have a major medical need*? ‘ Yes ‘ No
If yes, do you have: 1. Insurance available which you have not purchased? ‘ Yes ‘ No
2. Insurance that has ended in the past 60 days? ‘ Yes ‘ No
*Pregnancy is considered a major medical need. If you answered yes, enter the information in Section 3.

Ñ Is any other person required to pay medical expenses for anyone in your household? ‘ Yes ‘ No
If yes, person's name _____ Phone Number_____

æ Has anyone in your household ever served in the military? ‘ Yes ‘ No
Name_____ Dates of Service _____

Section 1 - Insurance Information (If you answered NO to question 1, do not complete this section)

Name of Insurance Company_____ Phone #_____
Address of Insurance Company _____ Group # _____
Policyholder Name _____ Policy # _____
If insurance is through an employer, list employer name and phone _____
Premium $_____ Date Due_____ How Often? _____
Names of Individuals Covered:

Name of 2nd Insurance Company_____ Phone #_____
Address of Insurance Company _____ Group # _____
Policyholder Name_____ Policy #_____
If insurance is through an employer, list employer name and phone _____
Premium $_____ Date Due_____ How Often? _____
Names of Individuals Covered (if not listed on the insurance card):

Section 2 - Accident or Assault Information (If you answered NO to question 2, do not complete this section)

Please check the type of incident: **9** automobile **9** assault **9** work-related **9** slip/ fall **9** dog bite
9 medical malpractice **9** other, please explain_____
Name of person(s) injured:_____
Date of incident:_____ Was a police report filed? ‘ Yes ‘ No
Police department: _____ Police Report Number: _____
Name of Attorney: _____ Phone number: _____

Section 3 - Buy-Out Information (If you answered No to question 3, do not complete this section)

Who has the medical need?_____ What is the medical need?_____
If you have had insurance end in the last 60 days, when did it end?_____
Name and Phone of Insurance Company_____
Policyholder Name_____ Policy # _____
Do you have insurance available which you have not enrolled in? ‘ Yes ‘ No
Employer Name & Phone (if applicable) _____
If not through an employer, how is insurance available?_____

L BEFORE YOU SIGN THIS APPLICATION, BE SURE YOU UNDERSTAND THIS INFORMATION 7

- I assure that all of the members of my household are U.S. citizens or aliens in lawful immigration status, unless I am requesting emergency medical assistance only. The Department of Health will verify reported alien registration numbers with the Immigration and Naturalization Service (INS). The Department will not report undocumented household members to INS.

- All the members of my household will obey the medical assistance program rules. If I receive medical assistance which I am not eligible to receive, I will be responsible for repaying the medical assistance. I will allow only the people named on the medical card to use the medical card.

- If the Utah Department of Health pays for my medical care, I assign to it my rights to payments from any third party and to benefits for medical services. I will give to the Department any money I collect from an insurance policy or from someone required to pay for my medical expenses. I authorize payment directly to the Department of Health or the Office of Recovery Services and will hold harmless any party making payment to them. I agree to cooperate with the State of Utah to establish medical support for my family and in pursuing any third party responsible for medical expenses. I agree to cooperate with the State of Utah to establish and collect alimony and child support for my family.

- I agree that the assistance I receive under any medical program is limited to that described in the Provider Manuals that the Utah Department of Health has written. I understand that the benefits I am eligible to receive may be changed without my knowledge or consent.

- I authorize any person or organization to release medical records or information about my health or the health of my dependents to the Department of Health, Division of Health Care Financing or designee. The Department of Health and the Department of Workforce Services may give health care providers information about my eligibility for medical assistance.

- The State has the right to recover from my estate all money spent to pay my medical bills if I receive Medicaid at any time while I am 55 years of age or older.

- I give permission for ANY INFORMATION LISTED ON THIS FORM TO BE VERIFIED. My medical benefits may be reduced, denied, or stopped because of information received. I understand that failure to report changes and any false information given on this application, or subsequently provided, may result in prosecution for fraud. I understand that I may ask for a fair hearing if I disagree with the decision made on this application.

**** *I (print name) _____, read or had read to me the statements on this page. I understand those statements. Under penalty of perjury, I swear that the answers I have given on this application are complete and correct. I am the person represented by the signature on this document.*

_____ _____ _____

Signature or Mark of the Applicant Signature of the Spouse or Representative Date

VOTER REGISTRATION INFORMATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today? G Yes G No

If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. Choosing to register or declining to register to vote will not effect the amount of assistance that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with Lt. Governor, Olene S. Walker, State of Utah, 203 State Capitol Building, Salt Lake City, UT 84114.

This Section To Be Completed By The Worker Worker Name _____

G May We Be of Service	G Medicare Cost Sharing (QMB, SLMB, QI'S)	G Rights & Responsibilities/476
G Estate Recovery Pamphlet	G SAVE	G Health Risk Assessment
G Assessment of Assets	G Estate Recovery (55+)	G HMO/PCP Orientation
G Parent Child Support Obligation		

Program Applied For _____ G Approved G Denied - Reason _____ Date _____

Program Applied For _____ G Approved G Denied - Reason _____ Date _____

Your Rights and Responsibilities

Your Rights:

- Apply or reapply any time you wish for any medical program offered by the Department of Health. Someone else may help you apply if you need help.

- Know why we approved or denied your application and the reasons for the decision. For medical assistance, we must give you a decision within 30 days or 90 days if you claim to be disabled unless you need more time.

- Know if we reduce, stop or hold your assistance and why. In most cases, we will tell you 10 days before we do this.

- Do the following things if you do not agree with decisions made regarding your case:
  A. Talk to your worker. Make sure you are not misunderstanding each other.
  B. Talk to your worker's supervisor.
  C. Talk to Constituent Services. The telephone number is 538-6417or call toll-free 1-877-291-5583.
  D. Request a Fair Hearing with an impartial Hearing Examiner.
  E. Request legal representation regarding your fair hearing. You may be entitled to free legal assistance from Utah Legal Services. In Ogden call 394-9431. In Salt Lake, call 328-8891. The toll free number is 1-800-662-2538. You may also receive a referral for legal advice from the Salt Lake Lawyer Referral at 531-9075.

- Look at the information collected by the Department of Health about your case. Information about you and your case is confidential. This information may be given to other agencies if they need information to administer a program to help you.

Your Responsibilities:

- **Verify Information**

  You must provide the Social Security number for each household member who wants medical assistance. If you do not have a number, you must prove you have applied. You may be eligible for assistance while you are waiting to receive a number. Giving us your Social Security number is required under the Social Security Act.

  Your Social Security number will be used with the State Income and Eligibility Verification System (an electronic match system) to make sure that your household is eligible for federal assistance programs. Computer matching, program reviews, and audits will be done with Job Service, Immigration and Naturalization, Social Security, and Internal Revenue Service records. We may also do inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about your household. Computer checks will be done when you apply after you receive assistance. You must give us proofs to show that you are eligible for assistance. If you do not understand what we need or you cannot give us the proof we are asking for, talk to your worker.

- **Cooperate**

  You must cooperate in any review of your case by Quality Control, Recovery Services, and the Bureau of Eligibility Services. You must also cooperate in providing information about any other sources of medical payments and obtaining medical support. If you feel you could be harmed by giving this information, you can request a 'good cause' claim. Your worker can explain this procedure. You must report changes in your circumstances.

  You and your household must also obey the medical assistance program rules.

BES

Department of Health

Form 476 01/00

CHANGES YOU MUST REPORT

Remember that you are required to report changes in your situation within 10 days of the day you learn of the change. Do not delay reporting changes. Changes can effect the amount of your benefits or your eligibility. If you receive more than you are eligible to receive, you will have to repay that amount.

CHANGE IN INCOME SOURCE

Getting a job, terminating a job, changing jobs, working for temporary services, educational income, SSI, SSA, or unemployment compensation, etc. Receiving a lump sum settlement.

CHANGE OF MORE THAN $25 IN EARNED OR UNEARNED GROSS MONTHLY INCOME

Working more OR less hours, overtime, getting a raise, terminating a job, etc. Change in SSI, SSA, Unemployment Compensation, etc.

CHANGE IN THE LEGAL OBLIGATION TO PAY CHILD SUPPORT

CHANGE IN MARITAL STATUS OR LIVING ARRANGEMENTS

Getting married, separated, or divorced; moving in with a roommate; absent parent moves in; birth of a baby; household member moves in or out; death of a household member; etc.

GAIN OR LOSS OF A VEHICLE (LICENSED OR UNLICENSED)

Car, truck, van, motorcycle, camper, trailer, recreational vehicle, etc.

CHANGE IN ANY ASSET

Stocks, bonds, property, vehicles, life insurance, trust funds, burial plans, cash, etc. for all household members. Open and closing of bank accounts. Includes joint ownership of any asset with spouse, parents, children, etc.

CHANGE OF MORE THAN $25 IN TOTAL ALLOWABLE DEDUCTIONS

Child care expenses, health insurance expenses, etc.

CHANGE IN INSURANCE COVERAGE

Changes in access to insurance coverage or enrollment in any health coverage plan for anyone in the household, accidents or injuries which may be payable by a third party.

Your Case Worker_____ Phone _____ Case #_____